

## Universal Claim Form

## **Step 1: Claim Information**

Today's Date:/	Number of pages: Resubmission of claim		Plan year beginning for: 20  Response to claim denial	
New Claim				
Step 2: Participant Information *=Required Fields		1		
*Employer Name (Do not abbreviate)		Department		
*Participant Name (First, MI, Last)		*Social Security Number		
*Participant Mailing Address Check here if change of address		Email Address (If provided, all notifications will be sent via email)		
*City		*State *Zip		
Step 3: Reimbursement Reques  Medical Reimbursement Account (FSA)  Dependent Care Reimbursement Account Individual Premium Reimbursement Account  *Employee, Spouse or Dependent Name	t *Amount Requ	10	doption Assistance Reimbu 5(h) Health Reimburseme *Date of Service	
Total Amount Requested:	\$			
Please note the following requirements for  Please number each receipt according to  IRS guidelines do <u>NOT</u> consider cancelle  Previous balances are <u>NOT</u> acceptable.  All reimbursements will be made payable	its order of appearance d checks as valid docu	on this form.		
	mum Reimburseme ** <b>Sign up for Dire</b>			
Step 4: Authorization				
To the best of my knowledge and belief, my statemed eligible expenses incurred during the applicable plane reimbursed on this or any other benefit plan and WI amount requested.	n year and for eligible p	lan participan	ts. I certify that these expe	enses have not been previously

SIGNATURE OF PARTICIPANT\_\_\_\_\_\_ DATE \_\_\_\_\_